CONFIDENTIAL REMEDIAL MASSAGE SCREENING FORM

☐Mr ☐Mrs ☐Ms ☐Miss ☐Master ☐Dr ☐Prefer no title Date of Birth ………………/………………/………………

First Name…………………………………………………… Last Name ………………………………………………

Ph – Mobile …………………………………………… Wk ……………………………… Hm ……………………………

Address ……

Suburb ……………………………………………………………………………… Postcode ……………………

Email Address ………………………………………………………… Occupation ……………………………………

Emergency Contact Name …………………………………………… Ph ……………………………………………

How did you hear about us? ☐ Physio ☐ Dr ☐ Word of Mouth ☐ Signage ☐ Internet ☐ I'm a past client

More details eg name of Dr or friend who referred you ………………………………………………………………

GENERAL HEALTH AND MEDICAL HISTORY:

Exercise Type/s ………

Exercise Frequency ☐ Rarely/Never ☐ Occasionally ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-7 days per week

Tick if you: ☐ Smoke ☐ Drink Alcohol ☐ Drink Caffeine

Have you taken any medications or supplements in the past 2 weeks including aspirin, anti-inflammatories, vitamins or herbs?

☐ No ☐ Yes – please list ……………………………………………………………………………………………………

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PLEASE TICK ✓ ALL CONDITIONS THAT YOU CURRENTLY HAVE OR PUT A "P" FOR PAST CONDITIONS:

___ blood clots / phlebitis
___ heart / circulatory problems
___ high / low blood pressure
___ history of stroke
___ cancer / tumours
___ lymph nodes removed
___ infectious diseases
___ epilepsy / seizures
___ abdominal / digestive problems
___ asthma / lung conditions

___ bone injuries
___ osteoporosis
___ arthritis
___ hernia
___ diabetes
___ skin conditions / rash
___ surgery
___ motor vehicle accident
___ numbness or tingling
___ muscle / soft tissue injuries

___ fatigue
___ depression / anxiety
___ mental health problem
___ insomnia
___ headache / migraine
___ vision problems
___ hearing problems
___ pregnant
___ miscarriage
___ endometriosis

___ allergies – please list: ……………………………………………………………………………………………

DETAILS FOR ABOVE CONDITIONS and/or ANY OTHER CONDITIONS, ILLNESSES, ACCIDENTS, SURGERIES:

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Do you currently have a contagious disease or virus? (eg cold, flu, covid-19, vomiting, diarrhoea, shingles etc)

☐ No ☐ Yes – details: ……………………………………………………………………………………………………

Are you currently having treatment for a medical/health condition?

☐ No ☐ Yes – details: ……………………………………………………………………………………………………

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TREATMENT:

Reason for seeking remedial massage treatment: ……………………………………………………………………………………

………

………

Brief history of current problem eg location, onset, duration, cause etc

………

………

………

SYMPTOMS: ☐ Pain ☐ Stiffness ☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Pins/Needles ☐ Constant ☐ Other

Frequency of symptoms: ………

Aggravating factors: ☐ activities ☐ posture ☐ movement ☐ rest ☐ ……………………………………………

Relieving factors: ☐ heat ☐cold ☐ movement ☐ rest ☐posture ☐ ……………………………………………

Do you have any concerns about your treatment?

☐ No ☐ Yes – details: ………………………………………………………………………………………………………

Are there any areas you would like avoided?

☐ No but I will tell if you I change my mind ☐ Buttocks ☐ Face ☐ Stomach ☐ Chest

Do you experience any difficulty lying on: ☐ your front ☐ your back ☐ N/A

CONSENT TO TREATMENT ✓ **Please tick the boxes once read.**

☐ I have chosen to consult with and hereby give consent for massage treatment to be provided by Remedial Massage Therapists at Re-Balanced Bodies.

☐ I understand that I have the right to refuse, request changes to or stop the treatment at any time and I will advise the therapist if the pressure applied or any aspect of the treatment is causing discomfort.

☐ I understand that the therapist has the right to refuse to provide massage treatment if he/she deems that I have a condition for which massage is contraindicated.

☐ I understand that massage therapists are not qualified to diagnose, treat illness or disease and anything said during the course of treatment should not be construed as medical advice.

☐ I have provided a detailed medical history and do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

☐ I understand that massage may provide benefits for certain conditions such as reduced symptoms of muscle-related conditions, relaxation etc but results are not guaranteed.

☐ I understand that massage may also produce temporary side effects such as headache, mild bruising, light-headedness, muscle soreness, tiredness or increased awareness of areas of pain.

☐ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the treatment.

☐ I consent to the conditions for collection of this information as outlined in our Privacy Policy on www.rebalancedbodies.com.au

☐ I declare that the information I have provided is, to the best of my knowledge, true and accurate.

…………………………………………………………………………………… ………………/……………/………………

Client Signature (or Parent/Guardian if client under 18 years of age) **Date**

Parent/Guardian Name ……………………………………………………… ***Office Use only:*** *Ltr*